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ORIGINAL RESEARCH

Building Health Commissioning Capability of Australia's Primary Health Networks –Service Providers' Perspective

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Introduction: Australia's health system is strong, but fragmented across primary, secondary, and tertiary care. Primary Health Networks (PHNs) were established to streamline non-hospital-based health services and improve service effectiveness and efficiency across Australia, which can be achieved by fostering strong relationships with providers to build commissioning capabilities. Successful commissioning depends on the providers' ability to respond to commissioning opportunities.

Objective: This study aimed to identify capability development opportunities that support service provider organisations commissioned by PHN to deliver effective and efficient services in primary care.

Methods: A mixed-method case study approach was used, including an anonymous online survey and a focus group discussion.

Results: The study confirmed the key factors for health commissioning success in the following four dimensions: workforce development, effective engagement, support and guidance, and strong relationships. The study further recommends seven key strategies for capability development, highlighting the need for PHNs to focus on building the capability of primary care organisations to establish strong markets and successfully commission services.

Discussion: Building strong relationships through effective engagement that features support and guidance for service provider organisations is critical for PHNs' commissioning success. All organisations must work collaboratively and fully appreciate the unique limitations constraining PHNs that impact community needs and health outcomes. Given the variations in the size and function of commissioned service providers, factors such as locally developed service models, program differences, and regional needs should be considered when planning specific capability building activities.

Conclusion: Understanding the challenges faced by provider organisations to support commissioning capability development is imperative for PHNs to successfully commission health and social care services. Identifying key actions to support capability development while building strong relationships and learning from the insights produced by this study will enhance service co-design and collectively strengthen the market's ability to meet the growing health needs of local communities.

Keywords: commissioning, primary care, primary health networks, capacity building, community, social care

Introduction

Australia has one of the best healthcare systems, with its healthcare system performance top the chart among Organisation for Economic Co-operation and Development (OECD)countries according to the 2024 Commonwealth Fund report.[1] Having a strong and well-designed primary care system that provides comprehensive non-hospital-based services is one of the keys to enhancing preventive and transitional care across primary secondary-tertiary settings while supporting the management of rising chronic diseases.[2] In Australia, in addition to the medical services provided by general practitioners in private practices subsidised by Medicare, primary care includes publicly funded community health and social care. Community health and social services may cover Aboriginal and Torres Strait Island health;

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alcohol and other drug services; domestic, family, and sexual violence support; health services in aged care; maternal and child health services, and mental health and suicide prevention.[3]

Despite ongoing efforts to improve coordination between general practitioners (GP), specialists, and hospital services, care fragmentation remains, where patients may experience disjointed care, diminishing the quality and efficiency of care and treatment.[4] The 2020 Commonwealth Fund International Health Policy Survey confirmed the existence of income-related disparities, long waiting times, inadequate strategies that support long-term patient-GP relationships, inadequate attention to patients' social needs, and poor access to mental health services etc.[4,5] In July 2015, 31 Primary Health Networks (PHNs) were established to streamline non-hospital-based health services across Australia,[6] enhance coordination among service providers, and improve the effectiveness and efficiency of primary care in meeting the healthcare needs of the community.[7,8] PHNs have been established to act as service commissioners rather than service providers that do not provide health services but use a comprehensive health planning approach to identify and prioritise service gaps and commission appropriate health services'[9] in the respective catchment areas. PHNs plan, purchase, and monitor services to meet local needs, coordinate primary care across providers, support general practices, and enhance service providers' capabilities in the provision of quality care. PHNs are primarily funded by the Commonwealth Government, with the core fundings supporting PHNs' strategic infrastructure and planning.

Commissioning health and social care services can improve service efficiency and enhance their value by engaging healthcare organisations in the provision of health and social care[10] when guided by a clear policy framework with well-defined targets.[10,11] Fundamentally, PHN commissioning includes assessing and prioritising primary care needs, determining the type of services needed, how such services should be funded, and which service providers should provide in the respective catchment area.[8,12] The key commissioning steps, guiding principles, enablers, and some special responsibilities[7,8,13] are detailed in Figure 1.

A recent study focusing on building PHN commissioning capability in Australia confirmed that PHNs' commissioning practices can positively affect PHN staff's confidence in their health commissioning practices.[14] The study further suggests the importance of PHNs' active engagement with service providers in co-designing commissioned services[14.] Embedding the voices of service users and providers in the commissioning process is essential to ensure that long-term outcomes rather than short-term benefits remain the focus of commissioned services.[15] To achieve this, PHNs need to engage in a way that goes beyond the traditional consultation and participation modes. Instead, it should emphasise the importance of co-designing services with consumers and providers to commission services and address priority

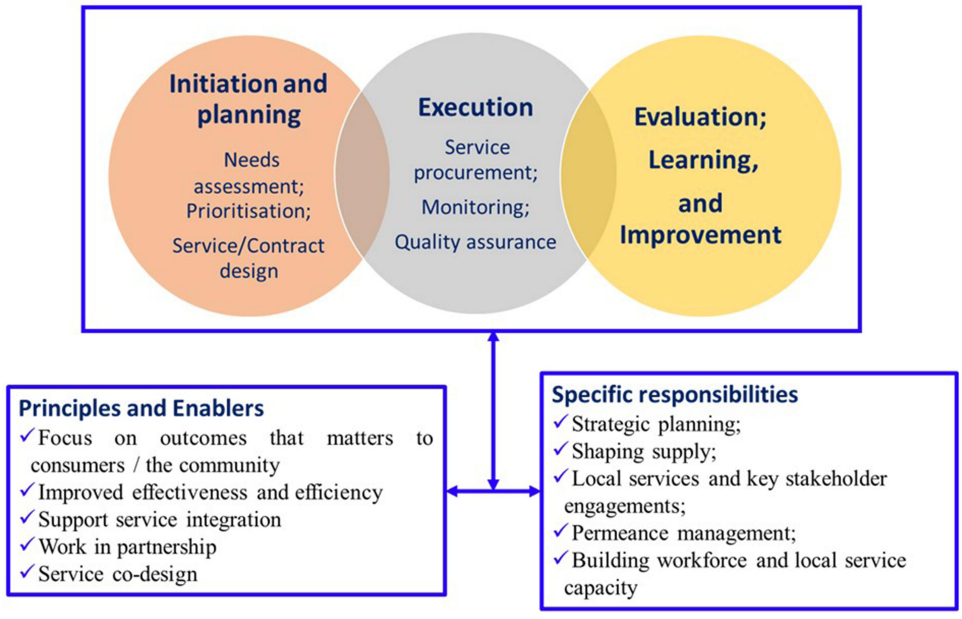

Figure 1 Key commissioning steps, principles and enablers.

outcomes.[15,16] Developing a deep understanding of the strengths and limitations of individual service providers is crucial. This requires time investment from the PHN staff to collaborate closely with providers and communities, ensuring that services meet the desired objectives, especially when primary care outcomes are difficult to define and measure. This is further complicated by the burden of varying key performance indicators (KPIs)and extensive reporting requirements faced by primary care organisations, particularly those involved in highly specified funding schemes.[15,17] As an integral part of the health system, PHN's success depends on their ability to commission primary care services effectively and collaborate with other sectors of the health system. To deliver tailored services and expected outcomes, PHNs must excel in building strong stakeholder partnerships and strengthening the capacities of local primary care providers.[8] Furthermore, service providers' capabilities in local decision-making, project leadership, management, and collaboration play crucial roles in the success of commissioning efforts.[10,18,19]

The Hunter New England and Central Coast PHN (HNECC PHN), one of the largest of the 31 PHNs in Australia, serving a population of 1.24 million across 130,000 square kilometers of regional, rural, and remote areas in New South Wales.[20] The HNECC PHN is guided by priority areas set by the Australian Government, including Aboriginal and Torres Strait Islander Health, Aged Care, Alcohol and Other Drugs, Digital Health, Mental Health, Population Health, and Workforce.[20] HNECC PHN recognised the need to build its capability to lead and manage the health service commissioning process, as well as to engage and support local service providers. Given the critical role PHNs play in supporting local service providers, it has been agreed that understanding how to provide the most appropriate level of support to strengthen their capabilities to deliver high-quality services that offer the best value for money is essential. This approach will improve the overall appropriateness, acceptability, effectiveness, and efficiency of the health commissioning process.

Project Aim

The project aims to provide evidence that will guide HNECC PHN in developing strategies to enhance the local service capability to engage with the commissioning process and successfully deliver commissioned assignments. This can be achieved by addressing the following overarching research questions.

1. What are the strengths and weaknesses of HNECC PHN in engaging local service providers in planning, delivering, and evaluating commissioned services?
2. How can HNECC PHN best engage and support local service providers in building the capability to deliver quality services?

Materials and Methods

Study Design

The study employed a case study approach focusing on HNECC PHN – one of the largest PHNs in Australia. A mixed-methods design was adopted, comprising an online survey and focus group discussions (FGDs) to collect data from two different participation cohorts: HNECC PHN staff and representatives from service providers in the HNECC PHN catchment. In the Australian context, PHNs act as commissioners, not service providers. They plan, design and commission primary, community and social care services to meet local needs. Therefore, building commissioning capabilities requires efforts between PHN and service providers. The mix-methods design aligns with this dual-role structure and enables a comprehensive exploration of building commissioning capability form both perspectives.

By engaging in and seeking contributions from different participant cohorts using different data collection methods, this study fully investigated the research questions. The online survey with HNECC PHN staff was conducted in May 2024 followed by a focus group with service providers one and a half month later. The focus group discussions also validated some information from the online survey and added depth by delving into the participants' experiences. The use of methodological and source triangulation enables the research team to develop a deeper and more nuanced understanding of how PHNs can best support service providers in enhancing their commissioning capabilities. Questions included in the staff survey in relation to

HNECC PHN's current support to and engagement with stakeholders, and the service providers' perception and expectations were compared and contrasted to draw a clearer picture of PHNs' role in enhancing providers' capabilities.

To ensure rigour of the overall study, the following strategies were employed:

- Methodological triangulation (survey + FGD),
- Source triangulation (PHN staff + service providers), and
- Members debriefing during coding and checking to validate interpretations.

Quantitative Component: Online Survey

An online survey using the questionnaire fully explained by Liang et al[20] was conducted in May 2024 using the Qualtrics platform. The survey participants were core employees of the HNECC PHN who managed or were directly involved in commissioning processes. The questionnaire was adapted from an instrument developed by Liang et al (2025). To ensure content validity, the survey items were reviewed by a panel of experts in health commissioning and PHN operations prior to deployment.

The main questions focused on the following areas.

1. PHN's current practices in service provider engagement and interaction with service providers during the commissioning process included nine multiple-choice questions using 7-point Likert Agreement scale: strongly disagree, disagree, slightly disagree, neutral, slightly agree, agree, and strongly agree.
2. Common difficulties encountered by PHN staff in planning and implementing commissioning work including 13 multiple choice questions using 7-point Likert Frequency Scale: Never; Rarely; Occasionally; Sometimes; Often; Very Often; Always.

Qualitative Component: Focus Group Discussion

A focus group was conducted with senior managers or program leads from service providers in the HNECC PHN catchment. The discussion explored:

1. Perceived strengths of HNECC PHN in supporting the current health commissioning process.
2. Challenges that service providers face during health commissioning work.
3. Service providers' expectations of PHN in supporting them during health commissioning work and contributing to building their health commissioning capability.

The FGD questions were informed by the key findings from the online survey and the FGDs with core PHN staff as detailed in the same study by Liang et al (2025) to ensure conceptual alignment and analytical depth. The discussion was audio-recorded, transcribed verbatim, and analysed using thematic analysis guided by Braun & Clarke's six-phase approach.[21]

Sampling and Recruitment

Purposive sampling was used for the online survey. The Commissioned Services Manager at the HNECC PHN emailed all 35 staff members who managed or were directly involved in commissioning and invited them to participate in the online survey. A participant information sheet and survey link were included in the email. An informed consent page was included at the beginning of the online questionnaire to receive implied consent from online survey participants. Reminders for participation in the survey were sent two weeks after the initial invitation.

For the focus group, one or two representatives (senior managers or program leads) from eight primary care providers within the HNECC PHN catchment areas, commissioned by the HNECC PHN to provide primary care services were invited to participate in virtual FGD. The targeted number of participants in the focus group was between 8 and 12. This is deemed suitable for online focus groups and ideal for ensuring data saturation.[22,23] The Commissioned Service Manager at HNECC PHN sent Email invitations to relevant contact people at ten local primary care or community

health service providers who were asked to forward the invitation to senior managers and program managers of the respective organisations. The Email invitation contained a link to a short survey where informed consent was included allowing potential participants to confirm their consent to participate in the FGD. Once consent was given, participants were then invited to provide their names, positions, organisations, and Email addresses. This link also provided several dates and times for the proposed FGDs, allowing potential participants to indicate their availability. The date and time that suited most representatives from service providers were then chosen for the FGD to be held. A calendar invitation, together with a link to a Microsoft Teams virtual meeting, was sent to the participants. Prior to the commencement of the online focus group discussion, participants were also invited to confirm that they had read the participant information sheet and provided informed consent to the participation.

Ethical Considerations

The Human Research Ethics Committee of James Cook University granted ethical approval on 23 May 2024 (approval H9451; expiry 30 September 2024). No names or other identifiable personal details were collected for this online survey. In the online focus group, each participant's name was replaced with a code in the focus group transcript to maintain anonymity. Informed consent to the inclusion of the anonymised responses/direct quotes to the publication were obtained from participants. No payment or remuneration was paid for FG participation.

Data Collection and Analysis

The data collected from the online survey were downloaded from the Qualtrics website in Microsoft Excel and checked for completion and error. Questionnaires with missing data from some sections were excluded from analysis. IBM SPSS Statistics version 29.0 was used to perform the analysis, including the mean of each question for all participants and management and non-management staff members. The percentage of participants who chose points 5, 6, or 7 on a Likert scale was also calculated. For a case study with a small sample that did not aim to explore differing views between management and non-management staff, the statistical significance of the mean scores between the two groups was not tested. The study was primarily exploratory, the sample size of 35 was sufficient to support descriptive statistical analysis. Although formal power calculations were not conducted due to the case study nature of the research, the sample included all core commissioning staff at HNECC PHN, ensuring comprehensive coverage of relevant perspectives.

A virtual focus group was created using Microsoft Teams (TEAMs) by a professional facilitator. The project principal investigator and note-taker also attended. Prior to the focus group session, a detailed schedule including questions to be discussed in the focus group was developed via a rigorous process. The focus group schedule was developed through a collaborative process between the facilitator, note-taker, and project principal investment. A draft schedule was sent to HNECC PHN for input to ensure that all questions were appropriate and relevant to the PHN context. The final preparation meeting was held prior to the focus group to ensure skillful facilitation and accuracy of the notes taken during the discussions.

Key questions asked during the FGDs included

1. Can you share experiences of a time when the commissioning process worked really well?
2. The commissioning process involved several steps. Based on your experience, which steps or aspects would you like more guidance and support from the PHN?
3. What are your suggestions as to what the PHN can do to help you take on more commissioned work?
4. If you had the task of supporting and guiding a service provider like yourself, what stood out as the most important thing you would do/provide to maximise your ability to take on commissioned work – name one or two?
5. In light of the key priority of PHNs in shaping the capabilities of local services to deliver commissioned health services, what do you think would be the most useful and helpful actions that PHNs and their staff could take to build local capability?

The focus group was video-recorded and transcribed via the embedded function of the MS and took 2-hours to complete. The note-taker took down all key points discussed in the focus group under each of the questions used to compare the results of the

thematic analysis performed by the principal investigator. Thematic analysis focused on developing concepts, categories, and themes guided by Braun and Clarke's (2019) six-phase reflexive thematic analysis.[21] Consolidated criteria for reporting qualitative research (COREQ) were applied to meet the recommended qualitative data reporting standards.[22,24] Participants were advised that a copy of the notes taken from the FG could be provided upon request.

Results – Online Survey

In total, 29 out of the 35 HNECC staff members who managed (n=13) or were directly involved in (n=16) commissioning fully completed the survey, representing an 83% response rate. Survey participants indicated their agreement with the 14 statements in relation to the PHN's engagement of stakeholders in assessing local needs, planning, co-commissioning, designing performance measures, and supporting service providers during the commissioning process. Figure 2 shows the percentage of staff members who agreed or strongly agreed with each of the 14 statements in relation to stakeholder engagement. Approximately 50% of the participants agreed or strongly agreed with statements 3, 4, 6, 8, and 10.

Elaboration of 14 stakeholder engagement practices

1. PHN's commissioning plan was developed informed by up-to-date and relevant health needs assessment data
2. PHN's commissioning plan has taken the capacity of local service providers into consideration adequately
3. My PHN has implemented effective strategies to engage key stakeholders including local service providers
4. My PHN has implemented effective strategies to engage consumers in contributing to PHN planning
5. My PHN has established clear strategies for taking consumers' feedback into account when evaluating the performance of local health services providers

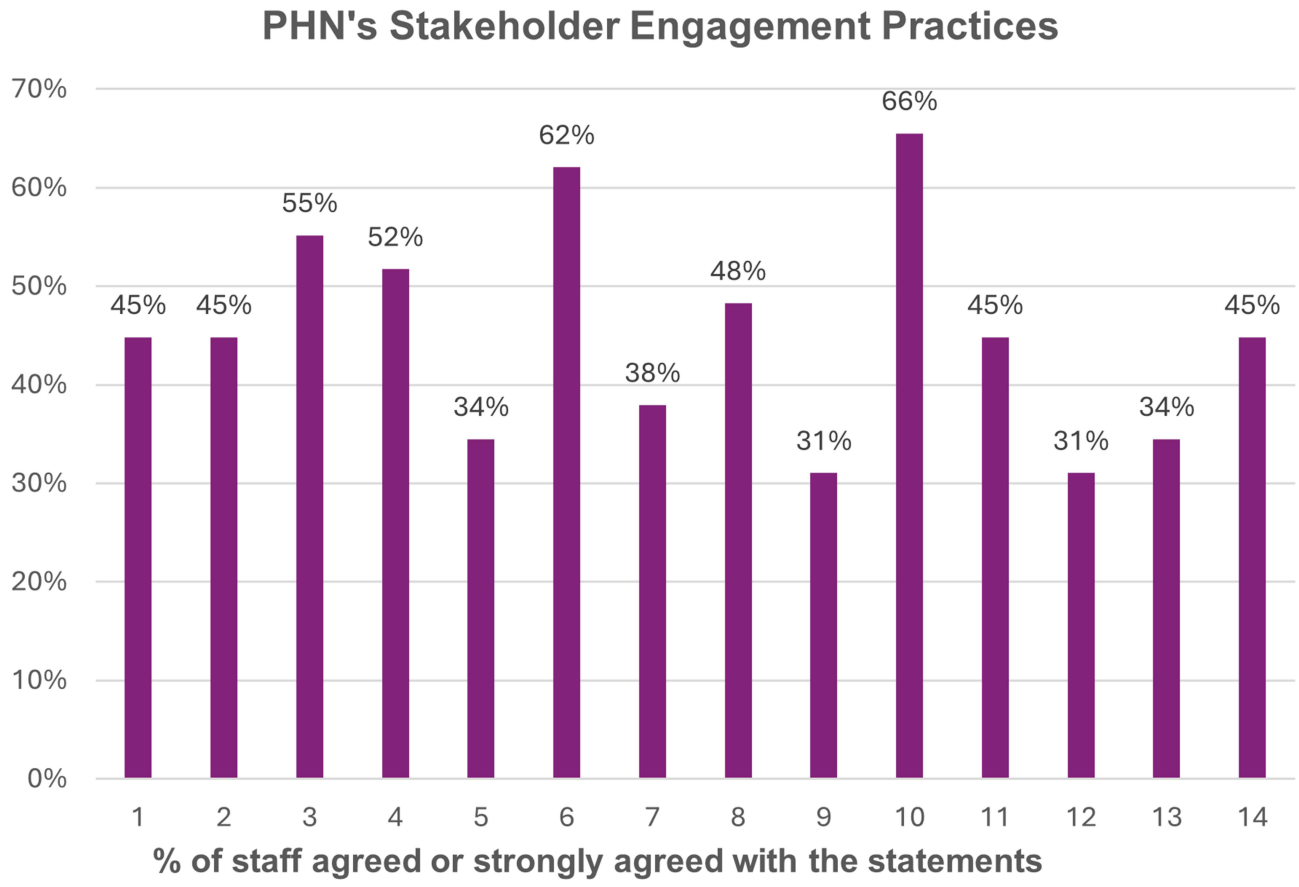

Figure 2 Percentage of staff agreed or strongly agreed with each of the stakeholder engagement practices.

6. My PHN understands the skills requirements of professionals / representatives of service providers who are engaged in the health commissioning process
7. I am confident that my PHN has fully engaged key stakeholders in setting PHN's strategic direction
8. I am confident that my PHN has fully engaged key stakeholders in developing the baseline needs assessment
9. We have dedicated time for planning for health commissioning
10. We have dedicated time for supporting local service providers in the implementation of commissioned services
11. We have dedicated time for supporting local service providers to collect relevant information that can be used to evaluate the commissioned services
12. My PHN has adopted the co-commissioning approach
13. Our PHN has the required expertise in achieving the benefits of co-commissioning
14. Our PHN has established strong relationships with local service providers to make co-commissioning a success.

Among the 13 difficulties provided, eight difficulties (1, 5, 6, 7, 8, 9, and 10) received an answer of 'often, very often", or "always" from more than 1/3 of the survey participants (Figure 3). More than 1/3 of non-management staff or management staff indicated that they "often" or "very often" or "always" encountered difficulties 6,7,8,9 and 10 or difficulties 1,5, 6 and 7.

Elaboration of the 13 difficulties

1. Access relevant data (service provider related) important to decision making in a timely manner
2. Assessing the suitability of service providers
3. Continuously engaging local service providers in contributing to PHN planning

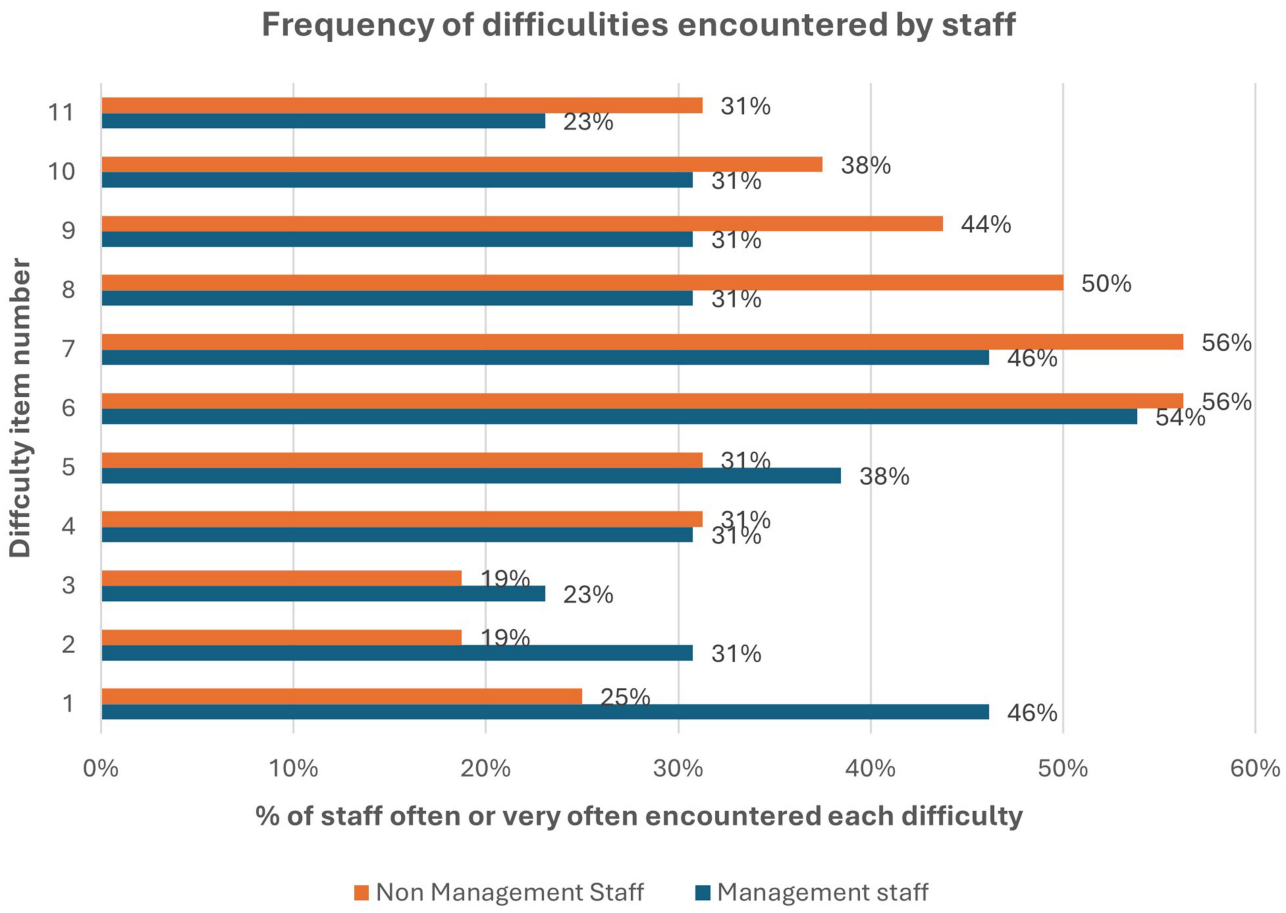

Figure 3 Percentage of staff often or very often encountered each of the difficulties.

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4. Continuously engaging local service providers in the health commissioning processes (including co-design, procurement and service delivery)
5. Critically assessing the performance of commissioned services
6. Establishing performance indicators that can objectively evaluate performance of PHN's commissioning process
7. Establishing performance indicators that can objectively evaluate performance of the commissioned services
8. Evaluating the outcomes of the commissioned services
9. Maintaining key stakeholders' active engagement
10. Negotiating with key stakeholders in agreeing on contracts and performance expectations
11. Providing constructive feedback to service providers based on available data / information.

Results - PHN Service Provider FGD

Key Factors for Health Commissioning Success

The participants discussed several contributing factors to the successful design and implementation of commissioned projects which were vastly related to four themes: effective engagement, support and guidance, building strong relationships, and workforce development. All these factors are shown in Figure 4.

Specifically, the participants stressed the importance of providing funding to support the piloting of new ideas and projects.

> We had a dream. We had a plan. We went to the PHN. They followed through and gave us funding for two years to roll out the suggested program. The outcomes are extraordinary, and it was just built on a dream.

They also highly appreciated HNECC PHNs' timely responses, willingness to listen, openness to suggestions, commitment to improvement, and engagement with service providers in planning health commissioning directions and assignments.

> So we had some really robust and productive discussions around developing the model that we were going to deliver to and that was done in a really great spirit, which was fantastic.

Participants also acknowledged that support from the PHN is crucial to enable organisations to take up projects that they may not be able to implement without assistance. Examples include understanding data collection/information systems, data collection, improving clinical governance, and corporate governance and structure.

> Some program funding, such as mental health, requires the collection of different data which is a lot more labour intensive for us to be able to fit it into mental health money. HNECC PHN helped us with that and supported us to be able to do that program.

Figure 4 Key factors for health commissioning success.

Current Challenges in Health Commissioning

Based on their experiences in the recently completed commissioned assignments, the participants shared six key challenges in designing and implementing commissioned work.

Challenge One: Report Frequency

The current quarterly reporting frequency was seen as a burden by service providers, particularly due to inconsistencies in reporting requirements such as varying levels of frequency and comprehensiveness across different funding schemes. Participants suggested that reporting should occur no more than every six months, with an annual frequency being preferable. However, they acknowledged the challenges of balancing this with the need to consider risk, performance, and financial stewardship. Striking the right balance is essential to ensure that the PHN can effectively monitor service quality, while allowing providers to focus more on delivering care.

Challenge Two: Change of Commissioning Process

The participants appreciated the need to make changes or modifications to the health-commissioning process, such as data collection. It is challenging for services to adequately plan and prepare for these changes when consultation and participation in their development are limited. Moreover, some of the planned changes may not have considered the limitations of service providers. This affects their ability to comply with required changes.

Challenge Three: Unclear Responsibilities of PHN Staff and PHN Support System

PHN teams are highly skilled in handling a wide range of situations and fulfilling responsibilities, many of which may not be clear to the service providers. This lack of clarity makes it difficult for service providers to determine who should turn to for support or advice when issues arise. Although HNECC PHN have developed effective support systems and mechanisms for service providers, these information or resources are not always well known or easily accessible.

> Maybe the PHN could look at in terms of making us more aware of who is on their team and their levels of expertise. The PHN is great for the patients, great for the staff and worked really well once we connected with the right staff.

Challenge Four: Contract Length

The current contract duration for PHNs, and in turn for commissioned work, is too short to allow effective planning and integration into existing organizational processes. It does not adequately account for the time required for project startup, implementation planning, or staff recruitment. Short-term contracts also hinder service providers from offering long-term employment to staff, making it challenging to attract candidates with expertise required for contract positions. A suggestion was made for PHNs to advocate the Department of Health Disabilities and Aging (DoHDA) for longer funding deeds which would allow the HNECC PHN to offer longer contracts when commissioning services. A minimum three-year funded contract would be advantageous and would better allow for the implementation and establishment of services. Focus group participants consistently highlighted the positive impact of extended contracts on service providers.

> We really need that extended contract period in order to successfully deliver the services to get the right people as well, because you want to recruit the best candidates for roles and it just makes it even harder to kind of get any specialists or people that have got certain qualifications depending on what the contract actually stipulates.

Challenge Five: Funding Scale and Additional Requirements

The service budgets and salary scales associated with contracts that are executed often do not adequately reflect service delivery costs, and this impacts service providers' ability to create or fill clinical positions with highly specialised professionals. This highlights a development opportunity to build financial literacy, recognising the need for business acumen for health system leaders and managers as part of the commissioning process. Furthermore, the salary scale proposed by organisations is often incompatible with that used by Local Health Districts (LHD) or competitor organisations, making recruitment even more challenging and the need to be seen as a competitively priced offering more crucial. This is compounded across commissioned programs, where DoHDA mandates specific awards, further limiting providers by dictating specific employment grading within state awards.

> The contracts are funded at a level where we have to pay below what you know, LHD staff might be getting paid and we're seeking staff with very specialized skill sets. So you know, we offer fantastic culture, great clinical supervision and employee value propositions, but it still doesn't compete with a higher hourly rate that the LHD can offer.

Additionally, some funding conditions, such as extra reporting and data collection requirements, project supervision, administrative support, IT support, and evaluation, are not adequately included in the budget or are considered as part of the real service costs. However, service providers often need to absorb such costs. While this may be manageable for larger organisations with internal teams and expertise, it presents a significant barrier for smaller organisations, making it difficult for them to take on critically needed commissioned projects.

> Setting up a new program from scratch is very, you know, management intensive and admin intensive. And there's just not the budget in there, but you know, over the next two years (the organisation needs) to cover those expenses.

Challenge Six: Data Collection and Evaluation

Data remain a significant challenge for commissioned services, as both the PHN and commissioned service providers struggle to obtain accurate data to drive improvements and support planning. Service providers have reported inconsistencies in PHN's data collection processes as well as complexities in the systems that support them. Given these complexities, it remains unclear how service providers can access and use their data effectively to track project progress and outcomes. The participants expressed concerns that the data generated by the current system often lacked the utility required to drive improvements. Data collection through providers' clinical record management (CRM) systems is often incomplete or contaminated through user errors, which limits the data that PHNs can share with service providers. Furthermore, there is confusion regarding the division of responsibilities between PHNs and service providers regarding data collection, access, and usage. Participants suggested that PHNs should be more receptive to feedback on their data collection procedures and systems and continue to refine the system and processes to support improvements in data quality, acknowledging the breadth of complexities associated with data collection and reporting while redesigning tenders and contracts to better align with reporting capabilities.

> I have found that the PHN has not been particularly open to feedback on that particular portion and again haven't been directed to the right people to rectify those.

Service providers also highlighted that a significant portion of project budgets was allocated to staffing costs, leaving limited funds available for evaluation, which is often not included in the project budget. Concerns have also been raised regarding the lack of confidence in establishing effective performance indicators for meaningful project evaluations. Service providers have expressed a strong need for clearer guidance and more support from PHNs. In addition, there were concerns regarding the purpose and focus of the current evaluation process. The existing evaluation tends to prioritise outputs (quantitative data) rather than focusing on outcomes (actual benefits), which are more valuable for generating insights that can drive improvements.

> Data collection / evaluation sometimes it's more of a numbers game than an outcomes game. It's more about actually making sure you hit your 70%,but not measuring whether there's an improvement. It's kind of a little bit not helpful in some ways.

Service providers emphasised that achieving improvements is one of the key reasons for their commitment to their work. Therefore, evaluations should demonstrate whether these improvements have been achieved, and whether their efforts and commitments are worthwhile.

Building Health Commissioning Capability – The Helpful and Useful Actions

Having discussed the success factors and challenges associated with the commissioning process, the design and implementation of commissioned activities, and lively discussions on what HNECC PHN's can do to address the challenges and build service providers' capability to take on and successfully complete commissioned work. Seven suggested actions are detailed in Table 1.

Table 1 Suggested Actions to Build Service Providers' Capability

Actions	Details
Action one: Health commissioning mapping	PHN provides a commissioning process map to clearly demonstrate the key steps and processes, responsibilities and expectation of service providers and the responsible person at PHN. "Sort of process map about commissioning and all the way through and seeing who's involved and what's our expectations are, what resources are available per program"
Action two: Collaboration between service providers	Within the same PHN catchment area, there is a diverse array of service providers with varying areas of expertise. PHN's role in facilitating connections and raising awareness among service providers can foster greater collaboration and strengthen the overall support network. "just an awareness of who is covering what so that we can leverage each other's programs or areas of expertise across our different organizations" Participants also noted that service providers can be seen as potential competitors, as they are all vying for funding from the same source. However, they acknowledged the importance of forming collaborative partnerships that create win-win situations—not only for individual funding success but also to share expertise and resources to better serve the community. PHNs have the opportunity to play a leading role in fostering these collaborative partnerships through formalised communities of practice established at a program level, or more broadly as local interagency opportunities. This approach not only fosters greater commitment to the commissioned work but also allows potential issues or problems to be identified early, enabling timely solutions to be implemented.
Action three Data collection and evaluation	PHN should make data collection and evaluation more relevant to understanding actual project performance and outcomes. The current evaluation process focuses more on activities completed rather than measuring real improvements and outcomes. There is a need for greater flexibility in evaluation design to better tailor it to the needs of service providers. Additionally, clearer guidelines on data collection and how results and success stories are shared between organizations would be highly beneficial. "some sort of flexibility in how that's captured in terms of performance and even working with First Nations and multicultural groups like how are we capturing meaningful data?" *(JH)* Participants also suggested the importance of providing clearer guidelines on reporting requirements, including the types of data to be collected and the rationale behind it. This would help service providers better understand the value of data collection and reporting, encouraging them to see it as a tool for improvement rather than merely an obligation.
Four Transparency on future funding opportunities	PHN should share its funding priorities and plans for funding arrangements over the next 12 months, giving service providers adequate time to assess whether they have the capacity to apply for funding and undertake additional projects. This would allow them to prepare and plan ahead effectively. "So having that more open and transparent and again, I do not know whether this is possible, but that more open and transparent view on what the PHN are expecting to look at over this next 12 months, which is beyond obviously their strategic plan…… for smaller organizations it would be helpful to know what that looks like for in the future". *(KB)*
Five Timely communication on employee movement and line of responsibilities	The diverse skills employed by PHNs play a crucial role in forming effective partnerships with local service providers and guiding them toward successfully completing commissioned work. PHN staff's ability to collaborate with service providers and actively seek and respond to feedback is highly valued. Given that turnover is common in healthcare organizations, it is essential to have a proper handover process when employees depart and to inform service providers about any personnel changes (such as in the commissioning coordinator role). This ensures that consistent working relationships between PHN and service providers are maintained. It is also vital to ensure that reporting lines and responsibilities are clear and communicated to service providers in a timely manner. Participants noted that managing projects with multiple reporting lines or requirements to different funding bodies can be confusing and burdensome. They cited the Headspace program as an example of this challenge. *"We run the headspace program and we're not unique in that space.* *A lot of other organizations are running headspace who are then reporting to Headspace National and then the PHN. It's not a happy family, it's, you know, this triangular system that we are trying to figure out - Who are the bosses here? Who do we report to in different things? And I think they are just, I really focus on that delineation, like how roles cause role clarity is important".*

(*Continued*)

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Table 1 (Continued).

Actions	Details
Six Longer term contracts	Participants highlighted the challenges of planning for future activities and managing existing commissioned work because contracts are often two years or shorter. Short-term contracts also make it difficult to attract and recruit highly skilled staff, as service providers are unable to offer more secure positions, rendering employment offers less attractive and competitive. Participants understand that the length of contracts offered by PHN is constrained by the current Commonwealth funding models. Therefore, it is crucial for PHN to advocate for changes to the funding model, particularly regarding the frequency and duration of contracts. Additionally, some service providers cover very large geographic areas, which means their staff often face significant travel demands. This should be budgeted and considered in tender responses to allow the contract to reflect this as part of the program funding. It was suggested that potentially offering financial subsidies for projects and staff, such as additional travel allowances or loading could be considered when providers are developing budgets to ensure the actual cost of service provision is remunerated. "we do a lot of rural and remote into really finite spaces across the New England NW". Participants also raised the concerns of the amount of time that their teams are required to spend on traveling in order to promote and provide services, very often such times were not considered in service planning or factored into funding proposals to allow travel to be reimbursed by the commissioned work.
Seven Provision of training /upskilling opportunities	Not all service providers have the budget or expertise to offer professional development opportunities to their staff. Support from HNECC PHN in providing such opportunities has been identified as being invaluable in building the capacity of local service providers to deliver high-quality services and engage in health commissioning work.

Discussion

More than half of the study participants acknowledged that the HNECC PHN had developed stakeholder engagement strategies and dedicated time to supporting service providers during the commissioning process. However, some expressed concerns about the adequacy of stakeholder engagement in developing the commissioning plan, strategic planning, and gathering stakeholder input when evaluating the performance of commissioned activities. Additionally, more than half of the study participants indicated that the HNECC PHN should review and improve its health needs assessment process to ensure that the commissioning process is informed by up-to-date data and appropriately consider the capacity of local service providers. Furthermore, over half the participants lacked confidence in PHN's expertise in adopting a true co-design approach to engage and support service providers throughout the commissioning process. However, this may be influenced by time constraints imposed by the DoHDA on commissioning exercises or by the PHN's commitment to rigorous probity processes to ensure fair and unbiased commissioning, rather than a reluctance to engage stakeholders.

It should be acknowledged that with less than ten years of experience since the establishment of PHNs across Australia, PHNs have achieved significant commissioning. Recent literature has highlighted the importance of adopting a new model / strategies to actively engage stakeholders and consumers in the service planning process to maximise the relevance and appropriateness of designed services.[14,15] This requires a shift in the existing mindset to view stakeholder engagement as value-adding when designing services, along with adopting a place-based approach to commissioning[25] while acknowledging the strategic importance of system-level support in both policy and funding.

Commissioning is more than a simple contract versus service provision encounter; it is an active process of co-design, co-planning, monitoring implementation and outcomes, and continuous improvement.[14,15] Commissioning is a process that demonstrates the close relationships formed between commissioners and service providers, with both parties being active partners in the planning, implementation and evaluation process.[14,15] However, it was recognised that financial constraints commonly facing PHNs often affect PHNs' financial and operational stability, resulting in fluctuations in commissioned service delivery, making shared decisions with providers as part of the commissioning process difficult.[18] The requirements imposed by the DoHDA on funding and reporting have also potentially diminished the success of the PHN commissioning model in facilitating collaborative partnerships and meeting prioritised local needs.[16]

The study confirmed that establishing performance indicators that can measure PHN's performance in the commissioning process and outcomes of commissioned services is a common challenge for both management and non-management staff. In the face of growing financial constraints and the complexity of healthcare needs, health systems are pressured to improve the efficiency and quality of care they provide. Proactive monitoring and evaluation of the care process and associated outcomes are critical for continuous quality improvement.[26,27] Enhancing the capabilities of PHN employees and service providers who manage and deliver commissioned services to establish meaningful performance indicators that can guide the collection of data is an important strategic investment that has not been ignored.[18,28] Establishing good performance indicators which lead to the collection of timely and relevant data that makes sense to decision-makers requires strengthened collaborative partnerships across organisations.[22,29] This is only possible when PHNs and local service providers collaborate early as part of the commissioning process, co-designing meaningful performance indicators, outcomes, and metrics through program logic modelling, which is completed ahead of service procurement or contract development. A Theory of change or logic modelling at the program level would clearly identify and map inputs, outputs, and outcomes for programs, while also identifying meaningful reporting metrics.[30]

The study confirmed several actions that PHNs can adopt to improve commissioning processes for service providers and encourage meaningful and productive collaboration between service providers, which will ultimately strengthen commissioning capability and processes. First, making roles and responsibilities within PHNs transparent to service providers would contribute to speeding up the negotiation, reporting, and problem-solving processes. Second, it provides a visualised commissioning process map detailing commissioning stages, common issues that are likely in each stage, and outlining reporting requirements to assist service providers with internal planning. Third, service providers should be assisted in adequately and accurately assessing their own capability to take on commissioned activities and identifying the potential skill gaps to be developed to make commissioned activities a success. Primary care organisations vary greatly in size, with differing levels of business acumen and the ability to recruit and maintain a highly skilled workforce by providing job security, targeted professional development opportunities, and clear career pathways.[31,32] Being in regional and rural areas further adds to the challenges of having a competitive advantage in staff recruitment, a commonly recognised challenge in Australia's regional and rural health.

This study argues that it is crucial for PHNs to play a more proactive role in providing skill development opportunities and removing potential constraints because of the contract length for commissioned work. Finally, by improving the local knowledge and the ability of service providers to integrate and have an awareness of what other services are available, and which organisations are delivering these services, PHNs are developing a platform and creating opportunities to build collaborative partnerships between service providers. Forming collaborative partnerships and encouraging multidisciplinary teams not only enable cross-learning and utilising the skills and experience of health professionals from different disciplines[33,34] but is also beneficial for addressing complex health needs.[35]

Both HNECC PHN employees and service provider representatives recognise the value of developing collaborative partnerships with local services to assess and prioritise community needs. This willingness to work collaboratively with local services, both individually and as a group, is crucial, with 83% of HNECC-funded program areas having the opportunity to access a community of practices, regular program forums or interagency event.[36] However, the current funding schedules often hinder the ability to address emerging and urgent community needs in a timely manner. The inflexible funding approach, limited frequency of funding rounds, and lack of periodic funding allocations have directly affected the active engagement of local services in the commissioning process[14] and their capabilities for innovation in service delivery. As Bates et al (2022) argued, the DoHDA should provide more flexible funding schedules to enable PHNs to respond more effectively to emerging issues.[18] Additionally, the length of contracts for commissioned work should be reconsidered to allow for long-term strategic planning, enhanced service capability, and the ability to attract and retain talent in local areas. PHNs must build provider capabilities in business acumen and address financial constraints and rigid funding structures imposed by the DoHDA to fulfil the role of commissioners and enhance their capability to develop long-term strategic plans, support workforce development, and foster innovation in service delivery. Addressing these challenges requires PHNs as a national group to strongly advocate the DoHDA for greater flexibility in commissioning funding schedules, longer contract durations, and improved transparency in the commissioning processes.

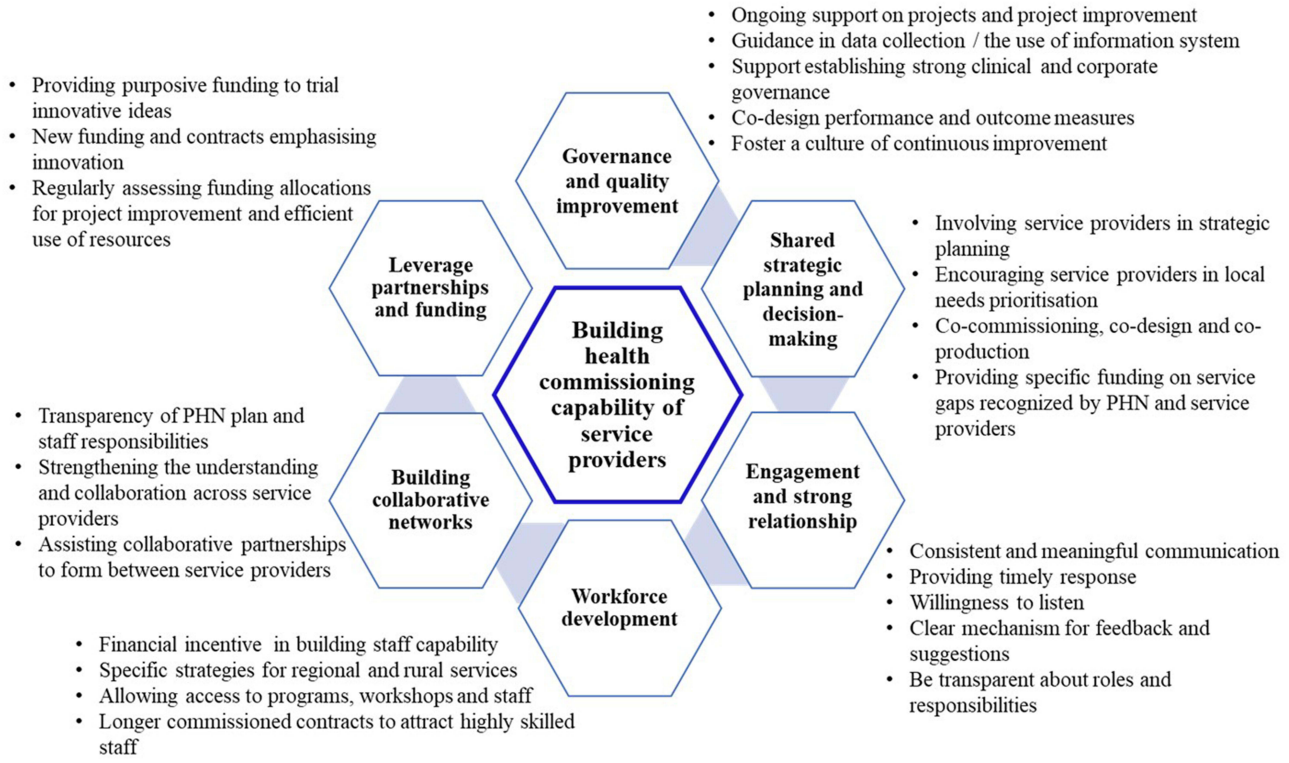

Figure 5 Strategies in building health commissioning capability of primary care service providers.

Through a mixed-methods approach, incorporating the insights and experiences of HNECC PHN employees and local service providers with recent health commissioning experience, the study identifies six key challenges and seven useful actions that translate into six key strategies to enhance the health and social care commissioning capabilities of local service providers. These strategies are essential to ensure that service providers excel in commissioned tasks and foster innovation. The details of these strategies are shown in Figure 5. Commissioning is not a linear process; its success depends on the formation of productive partnerships between commissioners and service providers tasked with delivering services.[12] The active involvement of PHNs in co-designing and co-planning commissioned initiatives with local service providers is crucial for promptly and effectively addressing health care needs. By building the capability of individual service providers to deliver more efficient and high-quality services, PHNs collectively strengthen their capabilities to meet the healthcare needs of their respective populations.

Conclusions

This study highlights both the strengths and challenges faced by PHNs and local service delivery organisations during the commissioning process. This underscores the need for greater efforts to effectively engage stakeholders in strategic planning, commissioning design, and performance evaluation. To enhance the impact of commissioning, PHNs should adopt a more collaborative place-based approach, ensuring that decisions are informed by local health needs, up-to-date health assessments, and the capacities of local service providers. As system leaders, PHNs play a critical role in fostering strong relationships between organisations, improving the understanding of the local health ecosystem, and facilitating clear and timely communication around commissioning decisions and changes. Strengthening the role of PHNs in capability building, system leadership, and performance monitoring will enhance service quality and efficiency, ultimately benefiting the communities they serve and driving meaningful improvements in primary healthcare commissioning and delivery.

Abbreviations

DoHDA, Department of Health Disabilities and Aging; FGD, Focus Group Discussion; LHD, Local Health District; PHN, Primary Health Networks; WHO, World Health Organization.

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Author Contributions

All authors made a significant contribution to the work reported, whether in the conception, study design, execution, acquisition of data, analysis, and interpretation, or in all these areas, took part in drafting, revising, or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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